

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1931 CERTIFICATE OF DEATH

Reg. Dist. No.

01924

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 16 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Robbins St.,	
d. STREET ADDRESS 117 Robbins St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martin Middle M Last Andrews		4. DATE OF DEATH Feb. 2, 1960 Month Feb. Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1908
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant Eastern Shore State Hosp.		10b. KIND OF BUSINESS OR INDUSTRY Chester, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Andrews		14. MOTHER'S MAIDEN NAME Anna Tyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-07-1807	
17. INFORMANT Mrs. Florence B. Andrews		Address Cambridge, Md. 117 Robbins St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach with Metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 17, 1959 , to Feb 2, 1960 , that I last saw the deceased alive on Feb 1, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Bannan		ADDRESS (Street, city or town, state) Cambridge DATE SIGNED 2-2-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel R. Horne		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR FEB 5 '60		DATE FEB 5 '60	
24b. REGISTRAR'S SIGNATURE Charles E. Horne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1932

CERTIFICATE OF DEATH

01925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland, Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cornersville, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First G. Middle Milbounre Last Barrack		4. DATE OF DEATH Month 2/21 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1884
9. AGE (In years lost birthday) yrs. 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Claudius Barrack		14. MOTHER'S MAIDEN NAME Mary Lydia Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Milbounre Barrack, Cornersville, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIO RENAL VASCULAR DISEASE WITH ANASARCA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-20-60 , 19____, to 2-21-60 , 19____, that I last saw the deceased alive on 2-21-60 , 19____, and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 2-22-60			
ACTUAL SIGNATURE Albert E. Bunker		M.D. 200 Maryland Avenue	
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M.D.		Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/60.	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.		ADDRESS 24a. REC'D BY REGISTRAR DATE MAR 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>William Lee Lee</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1/15/1915</u></p>		<p>4. Place of birth: <u>China</u></p>	
<p>5. Date of death: <u>1/25/1955</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Underlying cause: <u>Coronary artery disease</u></p>		<p>10. Contributing cause: <u>None</u></p>	
<p>11. Duration of illness: <u>Several months</u></p>		<p>12. Date of onset: <u>1/15/1955</u></p>	
<p>13. Name of attending physician: <u>Dr. J. Lee</u></p>		<p>14. Name of certifying physician: <u>Dr. J. Lee</u></p>	
<p>15. Signature of attending physician: <u>[Signature]</u></p>		<p>16. Signature of certifying physician: <u>[Signature]</u></p>	
<p>17. Date of certification: <u>1/25/1955</u></p>		<p>18. Place of certification: <u>Baltimore, Maryland</u></p>	

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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1933 CERTIFICATE OF DEATH

01926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>X RFD #1-Box #54-Cambridge</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Camper</u>				4. DATE OF DEATH Month Day Year <u>2 17 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-23</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Dor-Co-Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Herman Fisher-Pine St-Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension- Bronchial Asthma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December, 1954</u> , to <u>February 17, 1960</u> , that I last saw the deceased alive on <u>February 17, 1960</u> and that death occurred at <u>1 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md.</u> <u>2-19-60</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>227 Pine St-Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crossroad Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester-Co-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon H. King, Cambridge, Md.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01927

1934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glasgow Nursing Home</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> <u>05X-2</u>			
				d. STREET ADDRESS <u>Park Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Bradley</u> Last <u>Christopher</u>			4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 60</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 12, 1881</u>		9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Noble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records of Glasgow Nursing Home, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>1 day</u> <u>1 yr</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>60</u> to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>60</u> , and that death occurred at <u>7:25 P</u> .M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St</u> DATE SIGNED <u>2/20/60</u>			
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				<u>Cambridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Framptom and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. P. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of coroner		14. Signature of justice of the peace		15. Signature of health officer		16. Signature of other official	
17. Signature of other official		18. Signature of other official		19. Signature of other official		20. Signature of other official	
21. Signature of other official		22. Signature of other official		23. Signature of other official		24. Signature of other official	
25. Signature of other official		26. Signature of other official		27. Signature of other official		28. Signature of other official	
29. Signature of other official		30. Signature of other official		31. Signature of other official		32. Signature of other official	
33. Signature of other official		34. Signature of other official		35. Signature of other official		36. Signature of other official	
37. Signature of other official		38. Signature of other official		39. Signature of other official		40. Signature of other official	
41. Signature of other official		42. Signature of other official		43. Signature of other official		44. Signature of other official	
45. Signature of other official		46. Signature of other official		47. Signature of other official		48. Signature of other official	
49. Signature of other official		50. Signature of other official		51. Signature of other official		52. Signature of other official	
53. Signature of other official		54. Signature of other official		55. Signature of other official		56. Signature of other official	
57. Signature of other official		58. Signature of other official		59. Signature of other official		60. Signature of other official	
61. Signature of other official		62. Signature of other official		63. Signature of other official		64. Signature of other official	
65. Signature of other official		66. Signature of other official		67. Signature of other official		68. Signature of other official	
69. Signature of other official		70. Signature of other official		71. Signature of other official		72. Signature of other official	
73. Signature of other official		74. Signature of other official		75. Signature of other official		76. Signature of other official	
77. Signature of other official		78. Signature of other official		79. Signature of other official		80. Signature of other official	
81. Signature of other official		82. Signature of other official		83. Signature of other official		84. Signature of other official	
85. Signature of other official		86. Signature of other official		87. Signature of other official		88. Signature of other official	
89. Signature of other official		90. Signature of other official		91. Signature of other official		92. Signature of other official	
93. Signature of other official		94. Signature of other official		95. Signature of other official		96. Signature of other official	
97. Signature of other official		98. Signature of other official		99. Signature of other official		100. Signature of other official	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935 CERTIFICATE OF DEATH

01928

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Mill St.				d. STREET ADDRESS 204 Mill, St.			
3. NAME OF DECEASED (Type or print) First Wilbur Middle R. Last Dashiell				4. DATE OF DEATH Month 2 Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker				10b. KIND OF BUSINESS OR INDUSTRY Real Estate Broker		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William F. Dashiell				14. MOTHER'S MAIDEN NAME Mary Elizabeth Navy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. Wilbur Dashiell, Mill, St. Cambridge, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X PARKINSON DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 YEARS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 MAR. 1949 to 15 FEB. 1960 that I last saw the deceased alive on 30 JAN. 1960 and that death occurred at 4 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter E. Gunby Jr.				DATE SIGNED 2/17/60			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR Cambridge Maryland				ADDRESS (Street, city or town, state) 105 CHURCH ST.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/60.		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park.		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1965-10-15		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, MD	
10. DATE OF BIRTH 1920-05-20		11. SEX OF BIRTH Male		12. AGE AT BIRTH 45	
13. DATE OF DEATH 1965-10-15		14. TIME OF DEATH 10:30 AM		15. PLACE OF DEATH Home	
16. CAUSE OF DEATH Myocardial Infarction		17. MANNER OF DEATH Natural		18. PLACE OF BIRTH Baltimore, MD	
19. DATE OF BIRTH 1920-05-20		20. SEX OF BIRTH Male		21. AGE AT BIRTH 45	
22. DATE OF DEATH 1965-10-15		23. TIME OF DEATH 10:30 AM		24. PLACE OF DEATH Home	
25. CAUSE OF DEATH Myocardial Infarction		26. MANNER OF DEATH Natural		27. PLACE OF BIRTH Baltimore, MD	
28. DATE OF BIRTH 1920-05-20		29. SEX OF BIRTH Male		30. AGE AT BIRTH 45	
31. DATE OF DEATH 1965-10-15		32. TIME OF DEATH 10:30 AM		33. PLACE OF DEATH Home	
34. CAUSE OF DEATH Myocardial Infarction		35. MANNER OF DEATH Natural		36. PLACE OF BIRTH Baltimore, MD	
37. DATE OF BIRTH 1920-05-20		38. SEX OF BIRTH Male		39. AGE AT BIRTH 45	
40. DATE OF DEATH 1965-10-15		41. TIME OF DEATH 10:30 AM		42. PLACE OF DEATH Home	
43. CAUSE OF DEATH Myocardial Infarction		44. MANNER OF DEATH Natural		45. PLACE OF BIRTH Baltimore, MD	
46. DATE OF BIRTH 1920-05-20		47. SEX OF BIRTH Male		48. AGE AT BIRTH 45	
49. DATE OF DEATH 1965-10-15		50. TIME OF DEATH 10:30 AM		51. PLACE OF DEATH Home	
52. CAUSE OF DEATH Myocardial Infarction		53. MANNER OF DEATH Natural		54. PLACE OF BIRTH Baltimore, MD	
55. DATE OF BIRTH 1920-05-20		56. SEX OF BIRTH Male		57. AGE AT BIRTH 45	
58. DATE OF DEATH 1965-10-15		59. TIME OF DEATH 10:30 AM		60. PLACE OF DEATH Home	
61. CAUSE OF DEATH Myocardial Infarction		62. MANNER OF DEATH Natural		63. PLACE OF BIRTH Baltimore, MD	
64. DATE OF BIRTH 1920-05-20		65. SEX OF BIRTH Male		66. AGE AT BIRTH 45	
67. DATE OF DEATH 1965-10-15		68. TIME OF DEATH 10:30 AM		69. PLACE OF DEATH Home	
70. CAUSE OF DEATH Myocardial Infarction		71. MANNER OF DEATH Natural		72. PLACE OF BIRTH Baltimore, MD	
73. DATE OF BIRTH 1920-05-20		74. SEX OF BIRTH Male		75. AGE AT BIRTH 45	
76. DATE OF DEATH 1965-10-15		77. TIME OF DEATH 10:30 AM		78. PLACE OF DEATH Home	
79. CAUSE OF DEATH Myocardial Infarction		80. MANNER OF DEATH Natural		81. PLACE OF BIRTH Baltimore, MD	
82. DATE OF BIRTH 1920-05-20		83. SEX OF BIRTH Male		84. AGE AT BIRTH 45	
85. DATE OF DEATH 1965-10-15		86. TIME OF DEATH 10:30 AM		87. PLACE OF DEATH Home	
88. CAUSE OF DEATH Myocardial Infarction		89. MANNER OF DEATH Natural		90. PLACE OF BIRTH Baltimore, MD	
91. DATE OF BIRTH 1920-05-20		92. SEX OF BIRTH Male		93. AGE AT BIRTH 45	
94. DATE OF DEATH 1965-10-15		95. TIME OF DEATH 10:30 AM		96. PLACE OF DEATH Home	
97. CAUSE OF DEATH Myocardial Infarction		98. MANNER OF DEATH Natural		99. PLACE OF BIRTH Baltimore, MD	
100. DATE OF BIRTH 1920-05-20		101. SEX OF BIRTH Male		102. AGE AT BIRTH 45	

1

1936 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Rachael Last Dolby		4. DATE OF DEATH Month Feb. Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Hurlock Md. R.D.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Tubman		14. MOTHER'S MAIDEN NAME Rachael Insley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Leon F. Dolby, 208 Aurora St., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Enlarged Heart, Circulatory Failure (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-6 , 19 51 , to 2-13 , 19 60 , that I last saw the deceased alive on 2-12 , 19 60 , and that death occurred at 3:00 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 2-13-60	
ACTUAL SIGNATURE Albert E. Bunker M.D.		PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D. Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth L. Thow ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938
CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH OF THE DISTRICT OF COLUMBIA
OFFICE OF THE REGISTRAR OF DEATHS
No. 1000
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Race
Marital Status
Occupation
Signature of Registrar
Signature of Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG258 3-7-60 et

Reg. Dist. No.

01930

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville 09X-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle J. Last Doyle				4. DATE OF DEATH Month February Day 29 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14-1898		9. AGE (In years last birthday) 61 1/2 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lee Doyle				14. MOTHER'S MAIDEN NAME Unknown Tyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW1		16. SOCIAL SECURITY NO. 218-03-1005		17. INFORMANT Mrs. Thomas Doyle, Hoopersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> o. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Msce Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/29/60	
EXAMINER'S NAME (Type) John Msce Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3-60		22c. NAME OF CEMETERY OR CREMATORY Protestant Cemetery		22d. LOCATION (City, town, or county) (State) Fredensburg Rd. Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward G. Tule				ADDRESS 1000 G. Tule		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
				24b. REGISTRAR'S SIGNATURE Edward G. Tule			

EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1949 CERTIFICATE OF DEATH

01931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island., Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle L. Last Frazier				4. DATE OF DEATH Month 2 Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/29/1874	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 26 Days 19 Hours 60		11. BIRTHPLACE (State, county, city or town) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Waterman			
13. FATHER'S NAME George Frazier				14. MOTHER'S MAIDEN NAME Malinda Ruark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Delmar Willey Sr. Cambridge, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, gross DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart of aortic chronic INTERVAL BETWEEN ONSET AND DEATH 1 week ? ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 , to 1960 , that I last saw the deceased alive on Feb 25, 1960 , and that death occurred at Cambridge, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Feb 28, 1960 ACTUAL SIGNATURE James H. Thompson M.D. PHYSICIAN'S NAME (Type) James H. Thompson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60.		22c. NAME OF CEMETERY OR CREMATORY Brick Church Yard.		22d. LOCATION (City, town, or county) (State) Taylors Island, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR DATE MAR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

PLACE OF BIRTH MAINE		DATE OF BIRTH 10/10/1900	
SEX Male		RACE White	
MARRIAGE Single		OCCUPATION Laborer	
PLACE OF DEATH HOME		DATE OF DEATH 10/10/1944	
TIME OF DEATH 10:00 AM		PLACE OF INTERMENT BOSTON	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

1937 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge d. STREET ADDRESS 8 William Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Spencer Last Harris, Sr.		4. DATE OF DEATH Month February Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1884
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire & Rubber Salesman, Retired		10b. KIND OF BUSINESS OR INDUSTRY Chestertown, Md., R.D.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Spencer Harris		14. MOTHER'S MAIDEN NAME Mary Constable Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 245-09-4626	
17. INFORMANT Mrs. R. Spencer Harris		Address 8 William St., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 days 3 yrs			d.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/6 , 19 60 , to 2/18 , 19 60 , that I last saw the deceased alive on 2/18/60 , 19 60 , and that death occurred at 12.10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md. DATE SIGNED 2/18/60	
PHYSICIAN'S NAME (Type) Lawrence Maryanov			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 20, 1960	22c. NAME OF CEMETERY OR CREMATORY Old St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md. R.D.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas ADDRESS Cambridge, Md.		24a. RECEIVED BY REGISTRAR FEB 23 1960 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5591

1950 CERTIFICATE OF DEATH

01933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #1-Cambridge				c. LENGTH OF STAY IN 1b 60 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge-RFD #1				d. STREET ADDRESS RFD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Camper Last Haskins				4. DATE OF DEATH Month 2 Day 1 Year 19 60			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Sarah Jane Cephas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-10-6448			
17. INFORMANT Herman Fisher-Pine				Address St-Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Decompensation DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January , 19 54 , to February 1 , 19 60 , that I last saw the deceased alive on February 1 , 19 60 and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 2-4-60 ACTUAL SIGNATURE J. Edwin Fassett M.D. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/60		22c. NAME OF CEMETERY OR CREMATORY Rock Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge RFD #1, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon Henry Funr.Home, 222 Cedar St.				24a. RECEIVED BY REGISTRAR DATE FEB 12 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

Cambridge, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 257 2-11-60 215										STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01934						
1951										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY Dorchester					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural					c. LENGTH OF STAY IN 1b Life					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural					d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Franklin Last Hughes										4. DATE OF DEATH Month February Day 9 Year 19 60																
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1917			9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer					10b. KIND OF BUSINESS OR INDUSTRY Farm					11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John R. Hughes										14. MOTHER'S MAIDEN NAME Florence M. Hughes																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 212-16-7363					17. INFORMANT Address Margaret E. Fletcher, Hurlock, Maryland																
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 784.1 (b) Aspiration gastric contents DUE TO (c) Vomiting															INTERVAL BETWEEN ONSET AND DEATH Instant Instant											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																										
ACTUAL SIGNATURE John Mace Jr.										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED						
EXAMINER'S NAME (Type) Dr. John Mace Jr.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/13/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Feb. 13, 1960					22c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery					22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Prampton and Son, Federalsburg, Maryland										24a. REC'D BY REGISTRAR DATE FEB 16 '60					24b. REGISTRAR'S SIGNATURE Arthur L. Hanna											

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G259 3-30-60 et

01935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 209 Cedar Street	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Jolley		4. DATE OF DEATH Month 2 Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 75 years
9. AGE (In years last birthday) unk yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self employed		10b. KIND OF BUSINESS OR INDUSTRY hauling	
11. BIRTHPLACE (State or foreign country) Dor-Co-Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Evan Laws		14. MOTHER'S MAIDEN NAME Lizzie Jolley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unk	
17. INFORMANT unk		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1959 , to Feb 27, 1960 , that I last saw the deceased alive on February 27, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 2/29/60			
ACTUAL SIGNATURE J. Edwin Fassett		M.D. 227 Pine St-Cambridge, Md.	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Dor-Co-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon H. Henry, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. F...			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>36 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rear of 222 High Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u> d. STREET ADDRESS <u>222 Muir Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Monroe</u> Middle <u>James</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>29</u> Year <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Dec. 17, 1902</u>		9. AGE (In years last birthday) <u>57 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset County, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Jones</u>					
14. MOTHER'S MAIDEN NAME <u>Anna Mc Bride</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-03-5254</u>		17. INFORMANT <u>Emma Jones, Cambridge, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), state the underlying cause (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Notural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u>		EXAMINER'S NAME (Type) <u>ALFRED R. MARYANOV</u>		DATE SIGNED <u>3/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Cambridge, Maryland</u>		22e. (State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. [Signature]</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>		DATE <u>MAR 7 '60</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

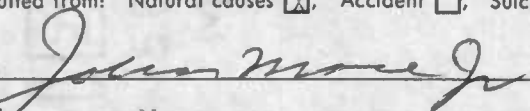
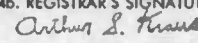
NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
A. J. JONES		Male		45		10/15/1968	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St., Baltimore, Md.		Teacher		Myocardial Infarction		Natural	
HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
Onset of chest pain 10/14/68, radiating to left arm.		None		None		None	
MEDICAL HISTORY		SURGICAL HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
Hypertension, 10 years.		Appendectomy, 1955.		None		Smokes 1 pack/day, 20 years.	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGIC EXAMINATIONS		TOXICOLOGIC EXAMINATIONS	
Vital signs stable. Heart normal.		ECG: Normal.		Chest X-ray: Normal.		None	
TREATMENT		POST-MORTEM EXAMINATION		SMALLER ORGAN SYSTEMS		GROSS ANATOMY	
Aspirin, morphine.		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE	
J. D. Smith, M.D.		10/15/68		10:00 AM		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01937

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vienna-Cambridge Road				d. STREET ADDRESS Vienna-Cambridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rodney Middle Lammont Last Jones				4. DATE OF DEATH Month February Day 28 Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1959		9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josiah D. Cephas				14. MOTHER'S MAIDEN NAME Gloria Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Gloria Jones, Vienna, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 096.9 DUE TO Virus infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John Mace, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR MAR 7 '60		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2067151XV5

EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
6. PLACE OF BIRTH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. TIME OF DEATH	
11. PLACE OF DEATH		12. SIGNATURE OF EXAMINER		13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF MINISTER	
21. SIGNATURE OF CHURCH		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF BURIAL PLACE		24. SIGNATURE OF CREMATOR		25. SIGNATURE OF INTERMENT	
26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT		28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT		34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT	
36. SIGNATURE OF REINTERMENT		37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT		40. SIGNATURE OF REINTERMENT	
41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT		43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT		49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT	
51. SIGNATURE OF REINTERMENT		52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT		55. SIGNATURE OF REINTERMENT	
56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT		58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT		64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT	
66. SIGNATURE OF REINTERMENT		67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT		70. SIGNATURE OF REINTERMENT	
71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT		73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT		79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT	
81. SIGNATURE OF REINTERMENT		82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT		85. SIGNATURE OF REINTERMENT	
86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT		88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT		94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT	
96. SIGNATURE OF REINTERMENT		97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT		100. SIGNATURE OF REINTERMENT	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01958

1940

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Orchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Bar</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Reliance</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Harry</i> Last <i>Kelley</i>		4. DATE OF DEATH Month <i>2</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/20/1889</i>
9. AGE (In years, last birthday) <i>70</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter-Rd.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Kelley</i>		14. MOTHER'S MAIDEN NAME <i>Margaret</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr John Shirley, Bedford, Dela</i>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/5/60</i> , 19 <i>60</i> , to <i>2/7</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/7</i> , 19 <i>60</i> , and that death occurred at <i>7 A.</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John Mace Jr</i> M.D. <i>C. Church St</i> <i>2/10/60</i> PHYSICIAN'S NAME (Type) <i>JOHN MACE JR</i> <i>Cambridge Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>2/10/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>		22d. LOCATION (City, town, or county) (State) <i>East New Market, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luther S. Hallock</i> ADDRESS <i>East New Market</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 15 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED _____	
2. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. AGE _____	
4. DATE OF BIRTH _____	
5. PLACE OF BIRTH _____	
6. OCCUPATION _____	
7. CAUSE OF DEATH _____	
8. PLACE OF DEATH _____	
9. TIME OF DEATH _____	
10. SIGNATURE OF DECEASED _____	
11. SIGNATURE OF WITNESS _____	
12. SIGNATURE OF PHYSICIAN _____	
13. SIGNATURE OF CLERK _____	
14. SIGNATURE OF JURY _____	
15. SIGNATURE OF JUDGE _____	
16. SIGNATURE OF SHERIFF _____	
17. SIGNATURE OF CORONER _____	
18. SIGNATURE OF DISTRICT ATTORNEY _____	
19. SIGNATURE OF COUNTY CLERK _____	
20. SIGNATURE OF STATE CLERK _____	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1941 CERTIFICATE OF DEATH

01939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				e. STREET ADDRESS 309 Sunburst Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Rosenberg Last Kidan				4. DATE OF DEATH Month Feb. Day 12 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1878	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months 3 Days whs.	IF UNDER 24 HRS. Hours 2 Min. yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jacob Rosenberg			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. Benj. Kidan, 309 Sunburst Highway, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x Carcinoma of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Coronary Heart Disease DUE TO (c) 2 yrs							INTERVAL BETWEEN ONSET AND DEATH 3 whs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 2/11 , 19 60 , to 2/12 , 19 60 , that I last saw the deceased alive on 2/12 , 19 60 , and that death occurred at 4:50 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Kace St		DATE SIGNED 2/13/60			
PHYSICIAN'S NAME (Type) Lawrence Maryanov		Cambridge, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-60	22c. NAME OF CEMETERY OR CREMATORY Bayside Cemetery		22d. LOCATION (City, town, or county) (State) Ozone Park, Queens Co., N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE Remeth D. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF FACTS ON DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Manner of death

6. Name of physician

7. Name of funeral director

8. Name of informant

9. Name of next of kin

10. Name of informant

11. Name of informant

12. Name of informant

13. Name of informant

14. Name of informant

15. Name of informant

16. Name of informant

17. Name of informant

18. Name of informant

19. Name of informant

20. Name of informant

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1953 CERTIFICATE OF DEATH

01940

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 1 mo., 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRIETTA MARIA KIRBY				4. DATE OF DEATH Month FEB. Day 21 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 10, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING & HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. WESLEY KIRBY				14. MOTHER'S MAIDEN NAME SUSAN JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL ARTERIOSCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from DEC. 30, 1959 , to FEB. 20, 1960 , that I last saw the deceased alive on FEB. 20, 1960 , and that death occurred at 7:44 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ettore De Filippis				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) ETTORE DE FILIPPIS				CAMBRIDGE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-60		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels MD	
23. FUNERAL DIRECTOR'S SIGNATURE Hamberton Harrison				ADDRESS St. Michaels MD		24a. REC'D BY REGISTRAR FEB 25 '60	
				24b. REGISTRAR'S SIGNATURE James L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01941

Reg. Dist. No.

1954

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. #2				d. STREET ADDRESS 1 R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Lee				4. DATE OF DEATH Month February Day 10 Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 28, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbershop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Washington Lee Sr.				14. MOTHER'S MAIDEN NAME Martina Johns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W II 217-10-8571		17. INFORMANT Thelma M. Lee Rt. 2. Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Bullet wound heart (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was beaten and shot to death by stepsons.					
20c. TIME OF INJURY Month, Day, Year Hour 10:30 a.m. 2/10/60 p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rural Cambridge, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10 2/15/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/60		22c. NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Cambridge, Dor. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St Clair				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1954

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. RACE</p> <p>5. OCCUPATION</p> <p>6. PLACE OF BIRTH</p> <p>7. DATE OF BIRTH</p> <p>8. DATE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. PLACE OF DEATH</p> <p>11. CAUSE OF DEATH</p> <p>12. MANNER OF DEATH</p> <p>13. SIGNATURE OF EXAMINER</p> <p>14. SIGNATURE OF WITNESS</p> <p>15. SIGNATURE OF CORONER</p> <p>16. SIGNATURE OF JURY</p> <p>17. SIGNATURE OF JUDGE</p> <p>18. SIGNATURE OF CLERK</p> <p>19. SIGNATURE OF SHERIFF</p> <p>20. SIGNATURE OF DEPUTY SHERIFF</p> <p>21. SIGNATURE OF CONSTABLE</p> <p>22. SIGNATURE OF DEPUTY CONSTABLE</p> <p>23. SIGNATURE OF TOWNSHIP CLERK</p> <p>24. SIGNATURE OF COUNTY CLERK</p> <p>25. SIGNATURE OF STATE CLERK</p> <p>26. SIGNATURE OF SECRETARY OF HEALTH</p> <p>27. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH</p> <p>28. SIGNATURE OF CHIEF OF BUREAU OF VITAL STATISTICS</p> <p>29. SIGNATURE OF CHIEF OF BUREAU OF PUBLIC HEALTH</p> <p>30. SIGNATURE OF CHIEF OF BUREAU OF LABOR</p> <p>31. SIGNATURE OF CHIEF OF BUREAU OF EDUCATION</p> <p>32. SIGNATURE OF CHIEF OF BUREAU OF AGRICULTURE</p> <p>33. SIGNATURE OF CHIEF OF BUREAU OF COMMERCE</p> <p>34. SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION</p> <p>35. SIGNATURE OF CHIEF OF BUREAU OF MINES</p> <p>36. SIGNATURE OF CHIEF OF BUREAU OF FOREST SERVICE</p> <p>37. SIGNATURE OF CHIEF OF BUREAU OF PARKS</p> <p>38. SIGNATURE OF CHIEF OF BUREAU OF RECREATION</p> <p>39. SIGNATURE OF CHIEF OF BUREAU OF HISTORIC PRESERVATION</p> <p>40. SIGNATURE OF CHIEF OF BUREAU OF ARCHITECTURE</p> <p>41. SIGNATURE OF CHIEF OF BUREAU OF ENGINEERING</p> <p>42. SIGNATURE OF CHIEF OF BUREAU OF SURVEYING</p> <p>43. SIGNATURE OF CHIEF OF BUREAU OF MAPPING</p> <p>44. SIGNATURE OF CHIEF OF BUREAU OF PHOTOGRAPHY</p> <p>45. SIGNATURE OF CHIEF OF BUREAU OF FILM</p> <p>46. SIGNATURE OF CHIEF OF BUREAU OF TELEVISION</p> <p>47. SIGNATURE OF CHIEF OF BUREAU OF RADIO</p> <p>48. SIGNATURE OF CHIEF OF BUREAU OF TELEPHONE</p> <p>49. SIGNATURE OF CHIEF OF BUREAU OF CABLE</p> <p>50. SIGNATURE OF CHIEF OF BUREAU OF MAIL</p> <p>51. SIGNATURE OF CHIEF OF BUREAU OF POSTS</p> <p>52. SIGNATURE OF CHIEF OF BUREAU OF SHIPPING</p> <p>53. SIGNATURE OF CHIEF OF BUREAU OF AIRCRAFT</p> <p>54. SIGNATURE OF CHIEF OF BUREAU OF SPACE</p> <p>55. SIGNATURE OF CHIEF OF BUREAU OF DEFENSE</p> <p>56. SIGNATURE OF CHIEF OF BUREAU OF ARMY</p> <p>57. SIGNATURE OF CHIEF OF BUREAU OF NAVY</p> <p>58. SIGNATURE OF CHIEF OF BUREAU OF AIR FORCE</p> <p>59. SIGNATURE OF CHIEF OF BUREAU OF MARINE CORPS</p> <p>60. SIGNATURE OF CHIEF OF BUREAU OF COAST GUARD</p> <p>61. SIGNATURE OF CHIEF OF BUREAU OF CUSTOMS</p> <p>62. SIGNATURE OF CHIEF OF BUREAU OF IMMIGRATION</p> <p>63. SIGNATURE OF CHIEF OF BUREAU OF NATURALIZATION</p> <p>64. SIGNATURE OF CHIEF OF BUREAU OF CITIZENSHIP</p> <p>65. SIGNATURE OF CHIEF OF BUREAU OF ELECTIONS</p> <p>66. SIGNATURE OF CHIEF OF BUREAU OF JUDICIARY</p> <p>67. SIGNATURE OF CHIEF OF BUREAU OF LEGISLATION</p> <p>68. SIGNATURE OF CHIEF OF BUREAU OF EXECUTIVE</p> <p>69. SIGNATURE OF CHIEF OF BUREAU OF GOVERNMENT</p> <p>70. SIGNATURE OF CHIEF OF BUREAU OF PUBLIC AFFAIRS</p> <p>71. SIGNATURE OF CHIEF OF BUREAU OF INFORMATION</p> <p>72. SIGNATURE OF CHIEF OF BUREAU OF COMMUNICATIONS</p> <p>73. SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION</p> <p>74. SIGNATURE OF CHIEF OF BUREAU OF INFRASTRUCTURE</p> <p>75. SIGNATURE OF CHIEF OF BUREAU OF UTILITIES</p> <p>76. SIGNATURE OF CHIEF OF BUREAU OF ENERGY</p> <p>77. SIGNATURE OF CHIEF OF BUREAU OF ENVIRONMENT</p> <p>78. SIGNATURE OF CHIEF OF BUREAU OF CONSERVATION</p> <p>79. SIGNATURE OF CHIEF OF BUREAU OF RECREATION</p> <p>80. SIGNATURE OF CHIEF OF BUREAU OF CULTURE</p> <p>81. SIGNATURE OF CHIEF OF BUREAU OF ARTS</p> <p>82. SIGNATURE OF CHIEF OF BUREAU OF LETTERS</p> <p>83. SIGNATURE OF CHIEF OF BUREAU OF SCIENCE</p> <p>84. SIGNATURE OF CHIEF OF BUREAU OF TECHNOLOGY</p> <p>85. SIGNATURE OF CHIEF OF BUREAU OF INNOVATION</p> <p>86. SIGNATURE OF CHIEF OF BUREAU OF RESEARCH</p> <p>87. SIGNATURE OF CHIEF OF BUREAU OF DEVELOPMENT</p> <p>88. SIGNATURE OF CHIEF OF BUREAU OF PLANNING</p> <p>89. SIGNATURE OF CHIEF OF BUREAU OF POLICY</p> <p>90. SIGNATURE OF CHIEF OF BUREAU OF STRATEGY</p> <p>91. SIGNATURE OF CHIEF OF BUREAU OF TACTICS</p> <p>92. SIGNATURE OF CHIEF OF BUREAU OF OPERATIONS</p> <p>93. SIGNATURE OF CHIEF OF BUREAU OF LOGISTICS</p> <p>94. SIGNATURE OF CHIEF OF BUREAU OF SUPPORT</p> <p>95. SIGNATURE OF CHIEF OF BUREAU OF MAINTENANCE</p> <p>96. SIGNATURE OF CHIEF OF BUREAU OF REPAIR</p> <p>97. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT</p> <p>98. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION</p> <p>99. SIGNATURE OF CHIEF OF BUREAU OF REFORMATION</p> <p>100. SIGNATURE OF CHIEF OF BUREAU OF REFORMATION</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01942

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>entire life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>300 Dorchester Ave.</u>						d. STREET ADDRESS <u>300 Dorchester Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Earle</u> Middle <u>Dean</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>February</u> Day <u>29</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1920</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interviewer State Unemployment Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Cambridge, R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Richard S. Lewis, Sr.,</u>						14. MOTHER'S MAIDEN NAME <u>Sue Dean</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-16-4544</u>		17. INFORMANT Address <u>Mrs. Doreen H. Lewis, 300 Dorchester Ave., Camb., Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mins.</u> <u>4 years +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-1-60</u>			
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>March 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Shuman</u>						ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 3 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND—STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 Film 6257 2-25-60 et

1955

CERTIFICATE OF DEATH

01943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 9M 11D	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Henry Matthews		4. DATE OF DEATH Month February Day 12 Year 1960	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 02 Days X-2	11. IF UNDER 24 HRS. Hours 00 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired water man		10b. KIND OF BUSINESS OR INDUSTRY WATERMAN	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel H. Matthews		14. MOTHER'S MAIDEN NAME Mary Alice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-12-3577	
17. INFORMANT Hospital records		Address Cambridge Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH UNK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1-59 , 19____, to 2-12 , 19 60 , that I last saw the deceased alive on 2-12-60 , 19 60 , and that death occurred at 2:50 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 2-12-60			
ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/60	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Home, Cambridge, Md		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1955

1

1

NAVY DEPARTMENT OFFICE OF RECORDS AND COMMUNICATIONS

1

01944

1943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Dor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN TB <i>6 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Madgaw Nursing Home</i>		d. STREET ADDRESS <i>Main St.</i>	
3. NAME OF DECEASED (Type or print) <i>John Edward Patten</i>		4. DATE OF DEATH <i>2 / 11 / 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/7/1874</i>
9. AGE (In years last birthday) <i>85</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Implement Dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr. Lewis F. Powell, Huntzdon Valley</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO <i>Generalized Arterio-Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>6 yrs.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1954</i> to <i>Feb. 11, 1960</i> that I last saw the deceased alive on <i>2-11</i> , 19 <i>60</i> , and that death occurred at <i>7:45</i> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Gilbert F. Meekins</i> M.D. <i>1944 Road & Cambridge</i>		<i>2-10-1960</i>	
PHYSICIAN'S NAME (Type) <i>GILBERT F. MEEKINS, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/13/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Northwood</i>	22d. LOCATION (City, town, or county) (State) <i>Chula, Tenn</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Hines</i>		ADDRESS <i>East New Market, Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>FEB 16 '60</i>		<i>Arthur S. Hines</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1963

DECEASED NAME LAST FIRST MIDDLE JAMES EARL RAY		SEX MALE		RACE WHITE	
DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA		MARRIED YES	
DATE OF DEATH APR 4 1968		PLACE OF DEATH MEMPHIS, TENN		DEATH RECORD NO. 100-443886-100	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
DATE APR 4 1968		DATE APR 4 1968		DATE APR 4 1968	
PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN	
I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
DATE APR 4 1968		DATE APR 4 1968		DATE APR 4 1968	
PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN	
I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
DATE APR 4 1968		DATE APR 4 1968		DATE APR 4 1968	
PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN		PLACE MEMPHIS, TENN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1963, CHAP. 43, § 1-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1963, CHAP. 43, § 1-102.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1956 CERTIFICATE OF DEATH

01945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Rural</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>2212-2</u> d. STREET ADDRESS <u>North Park Gardens</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC</u> <u>ROSENBERG</u>			4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>8</u> <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>scrap dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newark, N.J.</u>			
13. FATHER'S NAME <u>Louis Rosenberg</u>			14. MOTHER'S MAIDEN NAME <u>Jennie ?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>176-26-8116</u>		INFORMANT Address <u>Marvin Wiernick, 923 Division St., Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis with heart disease</u> 334x DUE TO _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome assoc. with cerebral arteriosclerosis with psychosis</u> 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>1/26/</u> , 19 <u>59</u> , to <u>2/8/</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/8</u> , 1960, and that death occurred at <u>10:15 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>E.S.S.H., Cambridge, Md.</u> DATE SIGNED <u>2/8/60</u> ACTUAL SIGNATURE <u>Simon Virkutis</u> PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Roosevelt Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Bucks County, Pa.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sydney Stillman</u>			ADDRESS <u>4324 No. Broad St.</u> <u>Philadelphia, Pa.</u>				
24a. REC'D BY REGISTRAR DATE <u>FEB 12 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1987

1987

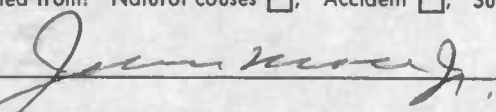
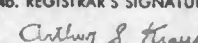
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01946

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 146 B. Washington St.				/d. STREET ADDRESS 146 B Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Calvin Middle J. Last Seymour				4. DATE OF DEATH Month Feb. Day 24 Year 19 60				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/ 1911		
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Road building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus Cornish				14. MOTHER'S MAIDEN NAME Estella Fletcher				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. 217-10-8705		17. INFORMANT Mahalia Seymour Address Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) 420.1							INTERVAL BETWEEN ONSET AND DEATH 30Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Dr. John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/25/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/60		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Dor. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair Jr.				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR MAR 2 '60		
				24b. REGISTRAR'S SIGNATURE 				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be executed the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE			
14. DISEASE OR INJURY (Print or Write)		15. SITE OF LESION (Print or Write)		16. NATURE OF LESION (Print or Write)		17. EXTENT OF LESION (Print or Write)		18. CHARACTER OF LESION (Print or Write)		19. COLOR OF LESION (Print or Write)		20. CONSISTENCY OF LESION (Print or Write)		21. TEMPERATURE OF LESION (Print or Write)		22. PULSE (Print or Write)		23. RESPIRATION (Print or Write)		24. BLOOD PRESSURE (Print or Write)		25. TEMPERATURE OF BODY (Print or Write)		26. WEIGHT (Print or Write)		27. HEIGHT (Print or Write)	
28. HISTORY OF DISEASE (Print or Write)		29. PRESENT ILLNESS (Print or Write)		30. TREATMENT (Print or Write)		31. PROGNOSIS (Print or Write)		32. COMMENTS (Print or Write)		33. SIGNATURE OF EXAMINER		34. DATE		35. TIME		36. PLACE		37. CAUSE OF DEATH		38. MANNER OF DEATH		39. SIGNATURE OF EXAMINER		40. DATE			

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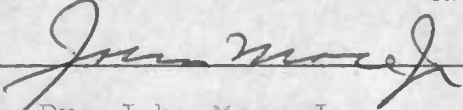
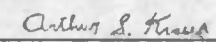
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge, Maryland, Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First L. Middle Phillip Last Skinner				4. DATE OF DEATH Month 2 Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Brokerage		10b. KIND OF BUSINESS OR INDUSTRY Insurance Brokerage		11. BIRTHPLACE (State or foreign country) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Skinner				14. MOTHER'S MAIDEN NAME Eugenia Wills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mildred Lee Skinner, Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial failure 78.2.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 30 Mins.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				DATE SIGNED			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/1/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60.		22c. NAME OF CEMETERY OR CREMATORY Christ Churchyard		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR DATE MAR 8 '60		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1948 Item 7 Film G258 3-7-60 et

Reg. Dist. No. 01948

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 15 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Phillips St. Ext.				d. STREET ADDRESS Phillips St. Ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Odessa Middle Spry Last 				4. DATE OF DEATH Month February , Day 19 , Year 19 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/15		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Herbert Anderson Address Phillips Ave. Ext.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Dor., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair Jr.				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR MAR 2 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01949

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 6 hrs-56 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS 5 St. Clair Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Stevens		4. DATE OF DEATH Month Day Year February 17 1960	
5. SEX female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-60
9. AGE (In years last birthday) 6 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Worthington Stevens		14. MOTHER'S MAIDEN NAME Dorothy Elizabeth Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Dorothy Stevens	
17. INFORMANT Dorothy Stevens		Address 5 St. Clair Avenue.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (23-24 wks) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 hrs 56 mins
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-17 , 19 60 , to 2-17 , 19 60 that I last saw the deceased alive on 2-17 , 19 60 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 15 Locust Street, Cambridge, Maryland 2-18-60			
ACTUAL SIGNATURE Eldridge H. Wolff M.D.		PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-60	22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair		ADDRESS High St. Cambridge	24a. REC'D BY REGISTRAR FEB 24 '60
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2067202XVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. SMITH</p>		<p>2. Sex: Male</p>		<p>3. Date of birth: 1-1-1900</p>		<p>4. Place of birth: Baltimore, Md.</p>	
<p>5. Date of death: 1-15-1950</p>		<p>6. Place of death: Home</p>		<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. J. H. Smith</p>		<p>10. Signature of registrar: John J. Smith</p>		<p>11. Signature of informant: John J. Smith</p>		<p>12. Date of filing: 1-15-1950</p>	

13. Remarks: **None**

14. Signature of registrar: **John J. Smith**

15. Date of filing: **1-15-1950**

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5B

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Creek</u>			c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Church Creek Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.</u>				d. STREET ADDRESS <u>R?F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah Elizabeth</u> Middle <u>Todd</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1881</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Major Travers</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cornish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Spencer Todd Church Creek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/4/60</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linus Rd. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Church Creek, Dor. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Clair Funeral Home</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

